PROVIDER HANDBOOK

72 HOUR PRESUMPTIVE ELIGIBILITY PROGRAM

September 2014

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CHAPTER ONE - GENERAL INFORMATION

1.1 Program Overview

The 72 Hour Presumptive Eligibility Program provides limited payment for crisis stabilization services delivered to adults who are not eligible for Medicaid. Any adult who is determined to be experiencing a psychiatric crisis is "presumed eligible" to receive medically necessary crisis stabilization services for up to 72 hours.

The responsibilities of the Addictive and Mental Disorders Division for the program include the following:

- establishing individual eligibility criteria;
- establishing standards for provider participation;
- establishing a fee structure for reimbursing crisis stabilization services;
- reviewing requests and authorizing reimbursement;
- keeping pertinent service documentation on file;
- establishing performance data to include:
    - services provided;
    - appropriate referrals to community resources;
    - frequency of return use;
- developing and maintaining reimbursement processes;
- providing training to mental health service providers who participate in the program;
- providing information about the 72 Hour Presumptive Eligibility program to consumers, their families, advocates and other stakeholders; and,
- working with Montana State Hospital (MSH) staff to track diversion from MSH.

AMDD has established a Benefit Management Team to administer key program operations including confirming individual eligibility, authorizing payment for covered services, and performing utilization review.

1.2 Provider Goals

The following goals have been established for providers who participate in this program. Providers must:

- participate in establishing and maintaining a coordinated and cohesive community service system for adults experiencing a psychiatric crisis;
- ensure that individuals are welcomed and experience coordinated care during crisis stabilization by:

    - utilizing and enhancing community based crisis stabilization interventions; and,
    - providing comprehensive, coordinated stabilization services in the least restrictive environment possible; and,
- provide advocacy and support for individuals experiencing a psychiatric crisis, their families, and their caregivers.

Meeting these goals will enhance the success of the program in effectively addressing the needs of adults experiencing psychiatric crises in Montana.

1.3 Handbook Use

This handbook has been prepared for enrolled providers who request reimbursement for services to individuals under this program. It also provides information on the requirements for provider participation, enrollment, and billing. This handbook can be viewed on the AMDD website at:

*www.dphhs.**mt**.gov/**amdd***

Revisions and supplements to the handbook will be released as operating experiences and applicable regulations require policy and procedure changes. The updates will be posted to the AMDD website listed above. Provider questions regarding specific procedures referenced in this handbook may be directed to the Benefit Management Team. The telephone number for AMDD is 406-444-3964.

Providers are responsible for complying with all policies and procedures contained herein. Failure to comply may result in sanctions, up to and including termination of enrollment as a provider of 72 Hour Crisis Stabilization Services.

CHAPTER TWO - DEFINITIONS

1. Adult: An individual who is 18 years of age or older.

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2. AMDD: Addictive and Mental Disorders Division.

3. Assessment: A face-to-face interview and observation by a participating mental health practitioner to evaluate the nature and severity of an individual's mental status/mental illness and make a determination of the intervention(s) needed to stabilize an individual.

4. Authorization: A determination indicating approval of payment for covered services and/or service units requested by the provider.

5. Benefit Management Team: The unit within the Addictive and Mental Disorders Division responsible for managing key program operations including confirming eligibility of the individual, enrolling providers, authorizing payment for covered services, and performing utilization review.

6. Care Coordination: The process of planning and coordinating care and services to meet an individual's mental health service needs. Care coordination includes:
    a. the development and monitoring of the crisis stabilization plan;
    b. identifying available natural and community services and supports for the individual being served;
    c. contact with others, as appropriate, for the purpose of supporting or assisting the individual being served;
    d. service coordination;
    e. referral; and,
    f. discharge planning.

7. CBPRS: Community based psychiatric rehabilitation and support.

8. Community Based Psychiatric Rehabilitation and Support: Services provided in community settings by trained mental health personnel according to individualized treatment plans. These services are provided on a face-to-face basis with the individual, family members or other key individuals in the individual's life.

9. Crisis: A serious situation resulting from an individual's apparent mental illness in which the symptoms are of sufficient severity, as determined by a mental health practitioner, to require immediate care to avoid:
    a. jeopardy to the life or health of the individual; or
    b. death or bodily harm to the individual or to others.

10. Crisis Care Manager: A trained mental health staff member who is responsible for managing the implementation of the crisis stabilization plan

until the individual is discharged from 72 Hour Presumptive Eligibility Program services.

11. Crisis Management Service: Facility based services delivered by an enrolled provider that may include, but are not limited to the following:
    a. observation of symptoms and behavior;
    b. support or training for self-management of psychiatric symptoms;
    c. close supervision of the individual being served;
    d. psychotropic medications administered during the 72 hour crisis stabilization period
    e. monitoring behaviors after the administration of medication; and
    f. laboratory services necessary for evaluation and assessment during the 72 hour crisis stabilization period.

12. Crisis Stabilization: The development and implementation of a short-term intervention to respond to the crisis, for the purpose of reducing the severity of the individual's psychiatric symptoms, in an attempt to prevent admission of the individual to a more restrictive environment.

    To be reimbursable, crisis stabilization services must be:
    a. medically necessary mental health services;
    b. delivered in direct response to a crisis as defined above;
    c. limited in scope and duration; and
    d. delivered or contracted for by a crisis stabilization provider.

    Crisis stabilization services are limited to:
    a. a psychiatric diagnostic interview examination;
    b. care coordination;
    c. individual psychotherapy;
    d. family therapy, with or without the patient present;
    e. one-to-one community based psychiatric rehabilitation and support;
    f. crisis management services; and
    g. services delivered by a primary care provider as defined in ARM 37.86.500 1(25), for screening and identifying psychiatric conditions and for medication management.

13. Crisis Stabilization Provider: A provider of services that is a legal entity enrolled under ARM 37.89.115 or a Medicaid enrolled hospital, and that has executed a provider enrollment addendum approved by the department.

14. Crisis Stabilization Service: An individualized psychiatric emergency intervention, provided in a safe environment, by an enrolled provider to:
    a. stabilize the crisis;
    b. gain diagnostic clarity;

c. find appropriate alternatives to more restrictive levels of care and treatment;
d. treat those symptoms that can be improved within a brief period of time; and,
e. arrange appropriate follow-up care and/or provide a referral for the most appropriate level of care and treatment.

15. Crisis Stabilization Plan: A brief individualized plan developed within the first 24 hours, based on the assessment, that:
    a. identifies the person serving as the Crisis Care Manager;
    b. lists problems identified by the psychiatric assessment;
    c. lists the individual's strengths, resources and any cultural considerations;
    d. lists attainable, clear, measurable goals for the presumptive eligibility period;
    e. identifies specific planned interventions and services to be offered during the presumptive eligibility period;
    f. identifies the referral and transition activities that occur at discharge; and,
    g. delineates specific responsibilities for implementing the plan including how services will be coordinated.

16. Cultural considerations: Any factors associated with an eligible individual that pertain to thoughts, communications, actions, customs, beliefs, and values associated with a racial, ethnic, religious or social group.

17. Department: The Montana Department of Public Health and Human Services

18. DPHHS: The Montana Department of Public Health and Human Services.

19. Eligibility Determination: A decision made by a participating mental health practitioner that an individual's situation meets the program definition of crisis.

20. Guardian: A person appointed by a court to make medical and/or financial decisions, as provided in Title 72, Chapter 5.

21. Individual: A client or recipient eligible to receive services under this program.

22. Medically Necessary Service: A service that is necessary to assess, diagnose, treat and/or prevent the worsening of conditions for an individual who is experiencing a crisis.

23. Mental Health Practitioner: An individual who is:

a. a licensed physician licensed under Title 37, chapter 3;
b. a professional counselor licensed under Title 37, chapter 23;
c. a psychologist licensed under Title 37, chapter 17;
d. a social worker licensed under Title 37, chapter 22;
e. an advanced practice registered nurse, as provided for in Title 37, chapter 8, with a clinical specialty in psychiatric mental health nursing; or,
f. a physician assistant licensed under Title 37, chapter 20 with clinical mental health experience.

The practitioner must be a provider enrolled in the 72 Hour Presumptive Eligibility Program or must be employed by or contracted by a provider enrolled in the 72 Hour Presumptive Eligibility Program.

24. Natural Supports: Any assistance, relationships or interactions that allow an individual to maintain and advance in his or her community in ways that correspond to the typical routines and social actions of other people and that enhance the individual's well being.

25. PA: Payment authorization.

26. Payment Authorization: For purposes of this program, a determination indicating approval of payment for covered services requested by the provider. A unique payment authorization number is issued to the provider for billing purposes.

27. Presumptive Eligibility: A period of up to 72 hours during which time-limited mental health crisis stabilization services will be reimbursed for an individual experiencing a crisis.

28. Provider: A person or entity that has enrolled and entered into a provider agreement with the department in accordance with the requirements of ARM 37.89.115. The provider must also have executed a 72 Hour Presumptive Eligibility Program Addendum that is approved by AMDD to provide assessment and crisis stabilization services covered under the 72 Hour Presumptive Eligibility Program.

29. Xerox: The fiscal agent for this program.

CHAPTER THREE – ELIGIBILITY

This chapter contains information on the eligibility requirements for services under the 72 Hour Presumptive Eligibility Program, eligibility determination, assessment procedures, and the responsibilities of the Benefit Management Team.

3.1 Eligibility Criteria

Eligibility for crisis stabilization services covered under the 72 Hour Presumptive Eligibility Program is determined by an assessment performed by an enrolled mental health practitioner. Adults in need of immediate care and services under this program must meet the following eligibility criteria:

***3.1.1 Age*:** Eighteen (18) years or older.

***3.1.2 Financial*:** There are no financial eligibility criteria.

***3.1.3 Eligibility Determination*:** A face-to-face interview by a mental health practitioner to determine whether or not the individual is presumptively eligible for program services.

***3.1.4 Diagnosis*:** A diagnosis is required for reimbursement for crisis stabilization services.

3.1.5 Duration: The Benefit Management Team authorizes an eligibility period of up to 72 hours from the date and time that the assessment is performed. If the assessment finds that the individual is experiencing a crisis, the eligibility period begins on the date the assessment is performed and may extend across four calendar days (72 hours) from this date. If the assessment concludes that the individual is not experiencing a crisis, the eligibility date span is limited to the date the assessment is performed, and reimbursement is limited to the assessment by the mental health practitioner.

3.1.6 Definition of a Crisis: To be eligible for services under the 72 Hour Presumptive Eligibility Program, the individual must be experiencing a psychiatric crisis defined as **"a serious situation resulting from an individual's apparent mental illness in which the symptoms are of sufficient severity, as determined by a mental health practitioner, to require immediate care to avoid:**

- **jeopardy to the life or health of the individual; or**
- **death or bodily harm to the individual or to others.**

This definition of crisis must be used in determining eligibility for crisis stabilization services reimbursed under this program.

3.1.7 Eligibility Determination: An enrolled mental health practitioner is responsible for making the determination that the individual's situation meets (or does not meet) the definition of crisis and is eligible (or not eligible) to receive medically necessary care and services reimbursable for a period up to 72 hours under this program.

The mental health practitioner must be enrolled as a crisis stabilization provider, employed by an enrolled crisis stabilization provider, or contracted by an enrolled crisis stabilization provider. Enrolled providers have executed a 72 Hour Presumptive Eligibility Program Addendum that is approved by AMDD, to provide psychiatric assessment and crisis stabilization services covered in the 72 Hour Presumptive Eligibility Program.

An individual who qualifies as an enrolled mental health practitioner for purposes of this program is limited to one of the following:

- licensed physician
- licensed professional counselor
- licensed psychologist
- licensed clinical social worker
- licensed psychiatric mental health nurse practitioner or clinical nurse specialist
- licensed physician assistant with clinical mental health experience

3.1.8 Presumptive Eligibility: Any adult who is determined to be experiencing a psychiatric crisis is "presumed eligible" to receive covered crisis stabilization services for up to 72 hours unless and until one of the following occurs within the 72-hour period:

- the individual refuses the service; or
- the individual is placed under emergency detention, court ordered detention, or civil commitment to Montana State Hospital; or
- the crisis is stabilized to the extent that emergency face-to-face outpatient services are no longer needed.

If the assessment determines the individual is experiencing a psychiatric crisis, no further eligibility determination is made.

An individual is **not** eligible to receive services under this program if he or she is currently enrolled in Medicaid or the individual has received services under this program within the previous seven days.

If eligibility is denied because services were provided within fewer than seven days following discharge from a prior presumptive eligibility period, the provider may request a reconsideration to determine whether payment is warranted.

The request for reconsideration should be mailed to the following address:

Benefit Management Team

Addictive and Mental Disorders Division

Post Office Box 202905

Helena, MT 59620-2905

The department will conduct an informal reconsideration and may grant full or partial reimbursement for services if it determines that:

- complications have arisen because of premature discharge or treatment errors in the previous crisis stabilization plan;
- the crisis stabilization services are for a condition that could not have been treated during the previous crisis stabilization plan; or
- the provider could not have discovered the previous stabilization plan using due diligence.

AMDD must receive a written request for review within 30 days after the date of a notice denying a claim.

3.2 Eligibility Determination and Assessment Procedures

The specific procedures for determining an individual's eligibility for services under the 72 Hour Presumptive Eligibility Program are described below.

3.2.1 Mental Health Practitioner

Mental health practitioners must follow the procedures listed below to determine and establish an individual's eligibility for program services:

1. Complete a face-to-face assessment and psychiatric interview with the individual immediately upon referral to determine if the individual's situation meets the definition of crisis.

2. Complete the first page of the 72 Hour Crisis Stabilization Program Form to record date and time of assessment, client information, provider information, and the results of the preliminary assessment including clinical information, referral information, presenting symptoms and behaviors.
   a. Indicate whether the individual is in crisis,
   b. Whether the individual is at risk to self and/or others, and
   c. The symptoms and behaviors causing the individual to be at risk to self and/or others.
   d. Enter a provisional diagnosis.
   e. Sign the form.

3. Deliver the 72 Hour Crisis Stabilization Program Form to the Crisis Care Manager.

Individual consent is not required for the emergency assessment of a mental health crisis.

3.2.2 Benefit Management Team

The Benefit Management Team located within AMDD is responsible for administering individual eligibility, provider enrollment, provider reimbursement and quality management functions for the 72 Hour Presumptive Eligibility Program. The Benefit Management Team reviews the 72 Hour Crisis Stabilization Program Form upon receipt to ensure compliance with eligibility criteria, including checking for Medicaid coverage. The eligibility for the 72 Hour Presumptive Eligibility Program will be entered within 10 business days. Enrolled providers can log in online to the Montana Access to Health Web Portal to view eligibility status,

CHAPTER FOUR - PROVIDER REQUIREMENTS

This chapter contains the provider enrollment, participation standards and record maintenance requirements for the 72 Hour Presumptive Eligibility Program.

4.1 Provider Participation Requirements

In order to enroll in the 72 Hour Presumptive Eligibility Program, a provider must:

1. be enrolled as a Montana Medicaid provider for mental health services;
2. execute a signed addendum to the Medicaid agreement, in which the provider agrees to participate in the 72 Hour Presumptive Eligibility Program and comply with all provider standards of participation listed below; and,
3. be approved by the Addictive and Mental Disorders Division (AMDD) to participate in the program.

A Medicaid provider who wishes to participate in the 72 Hour Presumptive Eligibility Program must enroll as a provider online via the Montana Access to Health Web Portal at:

https://mtaccesstohealth.acs-shc.com

The provider may contact the Montana Access to Health Web Portal Help Center at 1-800-624-3958 for assistance.

4.2 Participation Approval

When participation is approved, the provider will receive written notification of enrollment and the effective date of enrollment from Xerox . The date of the provider's signature on the addendum will be the effective date of enrollment unless the provider requests a specific enrollment date and it is approved by AMDD. Participation approval is not transferable.

4.3 Provider Standards of Participation

A provider must meet the following standards to participate in the 72 Hour Presumptive Eligibility Program:

1. have the capacity to recruit, hire or subcontract with, manage and train mental health professionals and other mental health staff;
2. have the ability to ensure the availability of immediate mental health assessment and crisis stabilization services;
3. ensure that staff and subcontractors providing the services are skilled in the delivery of mental health assessment and crisis stabilization services;
4. be capable of implementing appropriate and culturally competent care and treatment;
5. provide Care Coordination services for all eligible individuals served;
6. maintain a thorough knowledge of resources in the community and coordinate services with other community mental health service providers, county emergency services, law enforcement, and other necessary community services;
7. meet the data and fiscal requirements of AMDD to bill and receive reimbursement for covered program services;
8. submit accurate and complete claims for reimbursement as required by AMDD;
9. develop and maintain written policies and procedures regarding service provision and administration; and,
10. establish and maintain a quality assurance plan to evaluate the outcomes of services and individual satisfaction.

4.4 Provider Record Maintenance

The enrolled provider is responsible for maintaining complete, current and accurate files and records on all individuals served, including but not limited to records of individual services provided and billing and reimbursement records. Provider files must meet the HIPAA privacy and confidentiality standards as well as data maintenance and storage requirements established by DPHHS.

The provider must collect assessment data and maintain clinical records in accordance with ARM 37.1909 on all individuals who receive program services and ensure the confidentiality of clinical records in accordance with the Uniform Health Care Information Act, Title 50, chapter 16, part 5, MCA.

At a minimum, the clinical record must include:

1. crisis assessment;
2. a copy of the individual's crisis stabilization plan and all modifications to the plan;
3. progress notes which indicate whether or not the stated crisis stabilization plan has been implemented, and the degree to which the individual is progressing;
4. date of services, places of service delivery, signature of person providing the service, and the nature, extent, and units of services;
5. medication orders from the prescribing physician and documentation of the administration of all medications; and,
6. a discharge summary when the period of presumptive eligibility ends that includes documentation of the care coordination provided.

The provider must comply with the provisions of ARM 37.85.414 regarding maintenance of records and related issues and comply with the same confidentiality requirements that apply to information regarding Medicaid recipients. Each provider must maintain a record of care provided to an individual.

CHAPTER FIVE – SERVICES

This chapter describes the services covered in the 72 Hour Presumptive Eligibility Program, services and activities that are not covered by the crisis stabilization plan, and the role and responsibilities of the Crisis Care Manager.

5.1 General Guidelines

Crisis stabilization services may be provided during a 72 hour presumptive eligibility period to eligible individuals experiencing a mental health crisis. The services or interventions must be based on an assessment of the individual performed by an enrolled mental health practitioner. The 72 hour presumptive eligibility period begins on the date the assessment is performed. The crisis stabilization plan delineates the crisis stabilization services and interventions to be provided to the individual during the 72 hour presumptive eligibility period. The Crisis Care Manager is responsible for monitoring of the crisis stabilization plan.

5.2 Crisis Stabilization Services

Crisis stabilization services are medically necessary interventions to stabilize the individual to prevent more restrictive levels of treatment. The enrolled provider should deliver crisis stabilization services in a safe environment to resolve the immediate crisis and to stabilize the individual's psychiatric condition.

The goals of these services are to:

1. stabilize the crisis;
2. reduce crisis-related symptoms;
3. gain diagnostic clarity;
4. prevent, where possible, more restrictive service levels of care and treatment;
5. treat those symptoms that can be improved within a brief period of time; and,
6. arrange for the most appropriate level of follow-up care and treatment.

5.3 Assessment

An assessment based on the available information and mental status examination must be completed immediately by an enrolled mental health practitioner. The assessment must include:

1) a detailed explanation of the presenting problem, precipitating events, and current behaviors;

2) a description of the nature of the individual's impairments including discrete, observable symptoms and behaviors;
3) a risk assessment;
4) a determination of whether co-occurring substance-related disorders are present;
5) a provisional diagnostic formulation; and,
6) based on available information,
   a) relevant psychiatric and medical history that documents baseline behaviors and treatment history;
   b) relevant social history describing the individual's living situation, family involvement, cultural considerations, and strengths, resources, and natural supports.

5.4 Crisis Stabilization Plan

The crisis stabilization plan is a brief individualized plan developed within the first 24 hours following the assessment. The plan must be based on the assessment and be specifically tied to the symptoms and functional difficulties that led to the individual's crisis.

The complete crisis stabilization plan must:

1. Identify the Crisis Care Manager for the presumptive eligibility period.
2. List attainable, clear, measurable goals to be achieved during the presumptive eligibility period.
3. Identify specific interventions and services geared to meet the identified goals.
4. Provide details on interventions being used and services arranged including specific providers, where applicable.
5. Include available medications and dosage information noting any recent medication or dosage changes.
6. Indicate any medical conditions which are to be taken into consideration.
7. If the individual is receiving services from more than one provider, describe how the services are coordinated and supported to avoid the duplication of efforts.
8. Identify the referral and transition activities that occur at discharge.
9. Delineate specific responsibilities for implementing the interventions and services in the plan.
10. To the extent possible, include the client in the development of the crisis stabilization plan.

5.5 Covered Services

Crisis stabilization services are defined as individualized psychiatric emergency interventions and services provided in a safe environment. These services must be delivered or contracted for by an enrolled crisis stabilization provider.

To be reimbursed under the 72 Hour Presumptive Eligibility Program, crisis stabilization services must be time-limited medically necessary mental health services delivered in direct response to the crisis. The interventions and services must be delivered according to the crisis stabilization plan.

5.5.1 Crisis Stabilization Services

Crisis stabilization services reimbursable under this program are limited to:

1. psychiatric diagnostic interview examination (assessment);
2. care coordination;
3. individual psychotherapy;
4. family psychotherapy with or without the patient;
5. one-to-one community based psychiatric rehabilitation and support; and,
6. services delivered by a psychiatrist, physician, or mid-level practitioner as defined in ARM 37.86.5001(25), for screening and identifying psychiatric conditions and for medication management;
7. crisis management services.

The provider may bill for the psychiatric diagnostic interview examination (assessment) using CPT code **90791**.

All of the above covered services with the exception of care coordination and family therapy must be performed face-to-face with the individual to be reimbursed under the program.

These mental health services may be billed separately from the bundled crisis management services described in 5.5.2 below.

5.5.2 Crisis Management Services

Crisis management services include the following:

1. observation of symptoms and behavior;
2. support or training for self-management of psychiatric symptoms;
3. close supervision of the individual being served;
4. during the stabilization period;

5. psychotropic medications administered during the 72 hour crisis stabilization period;
6. monitoring behaviors after administration of medication; and
7. laboratory services necessary for evaluation and assessment during the 72 hour crisis stabilization period; and,
8. nursing services.

For billing purposes, crisis management services are paid on an all-inclusive bundled hourly rate to enrolled hospitals and enrolled facilities such as licensed mental health centers. Reimbursement of facility based crisis management services is subject to payment authorization (PA) and limits.

See Section 6.3 and Section 6.4 of this handbook for specific billing and authorization procedures that the provider must follow to receive reimbursement for crisis management services.

5.5.3 Care Coordination

Care coordination includes the following:

- the development and monitoring of the crisis stabilization plan;
- identifying available natural and community services and supports for the individual being served;
- contact with others, as appropriate, for the purpose of supporting or assisting the individual being served;
- service coordination;
- referral; and,
- discharge planning.

Payment for care coordination is subject to limits. See Section 6.3 of this handbook for specific billing procedures that the provider must follow to receive reimbursement for care coordination.

5.6 Services Provided in Detention Facilities

The 72 Hour Presumptive Eligibility Program provides reimbursement for services provided to an individual who is in protective custody or is awaiting trial. These services must include:

1. assessment, and
2. consultation to detention officers and/or medical staff.

An eligible individual in protective custody or who is awaiting trial in a detention facility must be offered individual psychotherapy.

Individuals who are serving sentences in detention facilities are not eligible for services under the 72 Hour Presumptive Eligibility Program.

5.7 Non-Covered Services

The 72 Hour Presumptive Eligibility Program does not provide reimbursement for the following:

1. services provided to individuals enrolled in Medicaid;
2. services provided by persons or entities not enrolled in the program;
3. services covered by another payment source;
4. services that do not meet service requirements, including staff that do not meet minimum qualifications for performing the service;
5. services following an assessment provided to an individual who is not determined to be in crisis;
6. services provided before or after the 72 hour presumptive eligibility period;
7. services that are not medically necessary and/or are not directly related to stabilizing the crisis;
8. room and board;
9. services performed by volunteers;
10. nursing home services or services provided by a nursing home facility;
11. any form of transportation furnished by a provider or to the individual;
12. strictly medical services;
13. services provided during a seven day period immediately following a covered 72 hour period of eligibility;
14. non-emergency mental health services;
15. long-term drug/alcohol treatment program service;
16. services to an individual under age 18;
17. prescribed medications; and,
18. client time in a waiting room before an eligibility determination is completed.

This is not an all-inclusive list of non-covered services. Providers must not assume a service is covered if it is not listed as non-covered.

5.8 Non-Covered Activities

The following activities are not reimbursable under the 72 Hour Presumptive Eligibility Program, either because they are not directly related to crisis stabilization or because the cost associated with the activity was already taken into account in the rates for billable services:

1. outreach activities;

2. direct billing for time spent “on call” when not directly delivering services during crisis stabilization;
3. performance of a service that would normally be billable, but the total time expended is less than half of the billable unit (e.g., less than 30 minutes for a one hour service unit);
4. activities required for completing or performing billable services (e.g., gathering files, reserving space, completing case notes, returning file material, clinical documentation, billing documentation, etc.);
5. unavoidable downtime;
6. personnel/ management activities;
7. staff training, orientation and development; and,
8. clinical supervision.

Questions regarding covered and non-covered services should be referred to the AMDD Benefit Management Team.

5.9 Role and Responsibilities of the Crisis Care Manager

The Crisis Care Manager is a trained mental health staff member who is responsible for managing the implementation of a crisis stabilization plan until the individual is discharged from crisis stabilization services. The Crisis Care Manager plans and coordinates care and services to meet the individual’s mental health service needs. Care coordination provided by the Crisis Care Manager is reimbursable under the 72 Hour Presumptive Eligibility Program. See Section 5.5.4 for a list of covered care coordination services.

If the individual currently is receiving mental health services, the Crisis Care Manager must attempt to coordinate interventions and the crisis stabilization plan with the individual’s current treatment providers and/or case manager. With the individual’s consent, an active attempt should be made to involve relevant family members and/or support systems in the assessment and discharge planning.

The Crisis Care Manager must arrange or ensure arrangement of a follow-up appointment upon discharge. If a determination is made to hospitalize the individual, the crisis care manager must assist and facilitate the individual’s admission to a hospital.

If the individual has a mental health case manager, the case manager must be involved in discharge planning. Care coordination and intensive outpatient services should be transferred to the community provider as soon as the crisis is stabilized or agreed upon by the Crisis Care Manager and crisis stabilization services provider(s).

All available care and treatment information including names and telephone numbers of current providers, provider NPI numbers, description of services provided, and medications (names, dosages and frequencies on medications prescribed) should be documented by the Crisis Care Manager.

The Crisis Care Manager is responsible for providing the following information on the 72 Hour Crisis Stabilization Final Report form:

1. provider and individual information;
2. final clinical information including diagnosis, problem list, strengths, resources and natural supports;
3. goals, interventions and cultural factors addressed;
4. discharge information; and
5. list of services provided including applicable procedure codes, dates, units and name and NPI number of provider(s) rendering the service(s).

The completed 72 Hour Crisis Stabilization Final Report form must be submitted by the Crisis Care Manager to the Benefit Management Team of AMDD within 60 days of admission**. Failure to promptly submit a properly completed 72 Hour Crisis Stabilization Final Report within 60 days of admission form may result in denial of the provider's claim for services rendered to an eligible individual.**

If bundled crisis management services requiring authorizations are listed on the 72 Hour Crisis Stabilization Final Report form, the Benefit Management Team will issue a payment authorization number biweekly for each of these services.

CHAPTER SIX – CLAIMS

This chapter contains the billing and claim submission requirements that providers must follow to receive payment for services rendered under the 72 Hour Presumptive Eligibility Program.

6.1 General Guidelines

Payments for covered crisis stabilization services rendered to eligible individuals, in a mental health center, an outpatient hospital setting and/or by mental health professionals are made upon submission of a properly completed claim form or electronic ANSI X12 transaction. These claims are processed by Xeroxusing the same claims processing system utilized for Montana's Healthcare Programs. Claims for Crisis Management services provided in a mental health center or an outpatient hospital setting by a participating facility require a Payment Authorization number (PA) issued by the AMDD Benefit Management Team. The Payment Authorization process utilized under the 72 Hour Presumptive Eligibility Program is similar to the Prior Authorization process used for other Montana Healthcare Programs. See Section 6.4 for more information on Payment Authorizations.

For detailed information on reimbursed services, please refer to Section 5.5 of this handbook on services.

6.2 Claim Forms

The CMS-1500 claim form or 837P format is to be used when billing for any professional or mental health services identified through use of CPTor HCPCS procedural codes. Such services are typically rendered by an individual or mental health center, not a hospital, and would include the following services covered under the program:

- one psychiatric diagnostic interview examination;
- psychotherapy services billed under appropriate CPT codes;
- pharmacologic management and evaluation and management services, billed under appropriate codes;
- face-to-face Crisis Management services rendered in a non-hospital facility setting. (See Section 6.3 for additional information);

- face-to-face Community-Based Psychiatric Rehabilitation and Support services rendered by a mental health center. (See Section 6.3 for additional information); and,
- Care Coordination provided by the designated Crisis Care Manager. (See Section 6.3 for additional information).

6.3 Procedure Codes

Adult mental health services fee schedules can be found at:

http://medicaidprovider.hhs.mt.gov/providerpages/providertype/59.shtml

Completed claim forms or electronic transactions must utilize current procedural (CPT, HCPCS) and diagnostic codes and modifiers approved for use in Montana's Healthcare Program. Currently, only valid ICD-9-CM diagnosis codes will be accepted for claims processing. At this time, DSM-V codes will not be accepted.

To facilitate claims payment under this program, providers should follow the billing guidelines delineated below:

6.3.1 Eligibility Determination and Assessment

Eligibility is determined by a mental health practitioner as defined in Chapter Two. An individual who is found eligible for this program must receive a psychiatric diagnostic interview examination.

The eligibility determination and initial assessment may be completed by the same clinician. In an outpatient mental health setting, a mental health practitioner must provide the eligibility determination and psychiatric diagnostic interview, which is billed as CPT.

In a hospital Emergency Department, a physician, psychiatric mental health nurse practitioner, clinical nurse specialist, or physician assistant with clinical mental health experience may provide the eligibility determination and bill an evaluation and management code. A mental health practitioner must provide the psychiatric diagnostic interview, which is billed as CPT.

6.3.2 Crisis Management Services

6.3.2.A Outpatient Mental Health Center settings

Facility based crisis management services rendered by a participating hospital on an outpatient basis, or mental health facility, including group homes and crisis centers, must be billed using HCPCS code **S9484** (Crisis Intervention Mental Health Services, Per Hour). **These codes require payment authorization.**

Since these services are reimbursed differently based on whether the services are rendered during the first 24 hours of the covered crisis, hours 25 through 48 or hours 49 through 72, **modifiers are required** to further differentiate these services as follows:

- For services rendered during the first 24 hours, enter the total number of hours in the units' field and include modifier "U1". (Half hour units of service are rounded up to the nearest hour.)
- For services rendered during hours 25 through 48, enter the number of hours in the units' field and include modifier "U2".
- For services rendered during hours 49 through 72, enter the number of hours in the units' field and include modifier "U3".

Individual one-on-one community based crisis management services rendered by trained staff employed by or contracted with a mental health center are **billed in 15 minute units** using HCPCS code **H2019. These services do not require a modifier or payment authorization.**

One-to-one community based psychiatric rehabilitation and support (CBPRS) must be provided by a trained person employed by or contracted with a mental health center.

EXAMPLE: An individual has been provided crisis management (e.g., CBPRS) services in a group home for 36 hours. The individual is discharged on day two to return home. The individual then receives five hours of CBPRS at home on day two and again on day three. The provider should bill using four line items as shown below:

Day	Procedure Code	Modifier	Units
One	S9484	U1	24
Two	S9484	U2	12
	H2019		20
Three	H2019		20

6.3.2.B Hospital Settings

Beginning July 1, 2014 inpatient hospital claims are processed by Xerox using the same claims processing system utilized for Montana's Healthcare Programs.

Any denied 72 Hour Presumptive Eligibility services will be kept on a spreadsheet for each facility and then is sent by AMDD to the facility on a monthly basis for review.

6.3.3 Care Coordination

Care coordination services rendered by the designated Crisis Care Manager must be billed in 15 minute units using HCPCS code **H2011**. Care coordination is subject to service limits of 12 units per episode of care.

6.4 Payment Authorization

Facility based outpatient crisis management services described in Section 5.5.2 of this handbook always require payment authorization (PA). Claims for these services rendered to individuals will be denied without a payment authorization.

The Benefit Management Team issues the payment authorization number(s) on a biweekly basis, after reviewing the completed 72 Hour Crisis Stabilization form submitted by the Crisis Care Manager. Formal notification of the payment authorization is forwarded via regular US mail to the provider by Xerox.

Claims for services that require payment authorization must be submitted with the payment authorization number indicated in the appropriate field on the claim form or loop and segment on the electronic transaction. The payment authorization number must be entered on the claim in the same manner as a prior authorization number is entered on claims in other Montana's Healthcare Programs.

Providers must bill according to the information supplied in the payment authorization letter. Each line on the claim must match the line information on the authorization exactly with respect to dates of service, procedure code, modifier (if applicable), and units of service.

If an eligible individual exits from services before he or she can be adequately identified for billing purposes, please contact the Benefit Management Team for reimbursement information.

6.5 Third Party Liability

Crisis stabilization services are covered under the program only when other coverage is not available. While the program is intended to provide services on a "presumptively eligible" basis, services are not reimbursed under this program if the individual is Medicaid eligible.

Participating providers must make a reasonable effort to determine if Medicaid, Medicare or other coverage may be available. If other coverage is available, claims must be submitted first to the other carrier. This will facilitate payment from the appropriate payer and minimize any instances where claim adjustments may be required to recoup funds previously disbursed.

When other liability cannot be determined, covered services will be processed for payment under the program. Should a provider bill both the program and another payer for covered services and receive payments from both sources, claims paid under the 72 Hour Presumptive Eligibility Program must be adjusted.

If the full amount of the payment made under the 72 Hour Presumptive Eligibility Program is received from another payer, then an Individual Adjustment Request for a claim credit must be filed. This will result in recovery of the full amount of the claim payment.

If the payment received from another payer is in an amount less than that paid under the 72 Hour Presumptive Eligibility Program, then an Individual Adjustment Request must be filed indicating the amount received from the other payer.

For detailed information on submitting an Individual Adjustment Request, consult the Provider Manual found on Montana's Healthcare Programs web-site at *mtmedicaid.org*. Provider office staff may also contact Xerox for assistance.

6.6 Claims Submission

Claims must be submitted to Xerox as soon as possible following the provision of services and, when applicable, receipt of the payment authorization information. Since this program is being funded by an annual Legislative appropriation, it is subject to available funding. Payments will cease upon discontinuation of funding. Therefore, claims must be submitted in a timely fashion. Timely submission will also allow AMDD to monitor the program.

All rules and regulations governing claims submission guidelines for Montana's Healthcare Programs apply to the 72 Hour Presumptive Eligibility Program

unless specific guidance to the contrary is stipulated in this Provider Handbook or other written communications from AMDD.

Reimbursement for crisis stabilization services is subject to post payment review and audit by the department, including record management and audit as provided in ARM 37.85.414. The department may collect from a provider any payment as provided with respect to Medicaid overpayments in ARM 37.85.406(9) through (10)(b).

6.6.1 Fee Schedule

Payments for covered services will be based upon the fee schedule adopted by AMDD and posted on their web-site at:

http://medicaidprovider.hhs.mt.gov/providerpages/providertype/59.shtml

Fees for covered professional services not specifically included in the AMDD fee schedule are paid based on the prevailing Montana Healthcare Program fee schedules.

6.6.2 Remittance Advice (RA)

The disposition of all claims processed by Xerox under this program appears on the regular Remittance Advice (RA). Claim status is communicated for all rejected, denied or paid claims on the RA. Claims appear on the RA by Provider ID (i.e. NPI) and within ID by the individual's Identifier. Claims processed under the 72 Hour Presumptive Eligibility Program are interspersed with claims processed under Montana's Healthcare Programs.

For more information about the RA, including specific codes and Explanation of Benefit messages, please refer to Montana's Healthcare Programs web-site at *mtmedicaid.org*.

6.7 Claims Inquiries

The status of claims processed under the 72 Hour Presumptive Eligibility Program is available through the same means used to search the status of Montana's Healthcare Programs claims.

These methods are:

- claim status on the secure MATH web portal;
- electronic Data Interchange claims Inquiry through submission of 276 transactions and receipt of 277 responses;
- electronic remittance advice, 835, for providers registered for receiving their RA's electronically; and,
- printed remittance advice (for providers receiving manual checks on an every other week basis only).

For detailed information on these options, please consult Montana's Healthcare Programs web-site at *mtmedicaid.org*.

6.8 Fiscal Records Management

Under the 72 Hour Presumptive Eligibility Program, providers are required to maintain records of services provided in accordance with the standards governing Montana's Healthcare Programs. Records must fully demonstrate the extent, nature and medical necessity of services provided to 72 Hour Presumptive Eligibility individuals which support the fee charged or payment sought and which demonstrate compliance with applicable requirements.

These records must be retained for a period of at least six years and three months from the date on which the service was rendered or until any dispute or litigation concerning the services is resolved, whichever is later. This includes retention of billing records and patient records relating to any billable activities. Specific requirements can be found in ARM 37.85.414.

6.9 Fiscal Audits and Reconciliation

Providers under the 72 Hour Presumptive Eligibility Program are subject to fiscal audits and reconciliation reviews under the same conditions that apply to Montana's Healthcare Programs.

The Department of Public Health and Human Services, the designated review organization, the legislative auditor, the Department of Revenue, and their legal representatives have the right to inspect or evaluate the quality, appropriateness, and timeliness of services performed by providers, and to inspect and audit all records required by ARM 37.85.414. Any such formal audits may be conducted under the auspices of the Department of Public Health and Human Services by providing notice as stipulated in the provider's Montana Healthcare Programs Agreement.

Additionally, providers participating in the 72 Hour Presumptive Eligibility Program must comply with any reasonable request from AMDD to perform periodic quality reviews related to services rendered under the 72 Hour Presumptive Eligibility Program. Such reviews may take place on-site at the provider's location where services were rendered or at the business office where records of such provided services are maintained. Any such reviews would only occur during normal business hours. Reasonable notice would be provided as to the date and time DPHHS designated staff would be on-site and as to the number and/or type of records that would be reviewed.

6.10 Provider Direct Billing

Providers are not allowed to direct bill the individual or require upfront payments for any services covered under this program. The provider agrees to accept payment under the AMDD fee schedule as payment in full for any covered services and, therefore, is prohibited from balance billing the individual for any amounts over the amount paid for such covered services. Any instances of prohibited billing will subject the provider to immediate termination of their participation in the 72 Hour Presumptive Eligibility Program and may be reported to DPHHS for further action.

Covered services are those that may be reimbursed by the 72 Hour Presumptive Eligibility Program for the particular individual if all applicable requirements are met. Non-covered services are those that may not be reimbursed for the particular individual by the 72 Hour Presumptive Eligibility Program under any circumstances.

A provider may bill an individual for non-covered services if the provider has informed the individual in advance of providing the services that AMDD will not reimburse for the services and that the individual will be required to pay privately for the services, and if the individual has agreed to pay privately for the services.

The individual must be informed of the specific service, along with date and cost of service for which he/she will be responsible for payment. Also, the provider may not bill for amounts in excess of the amount allowed under the applicable Montana Healthcare Programs' fee schedule.

The agreement to pay privately must be based upon definite and specific information given by the provider to the individual indicating that the service will not be paid by the 72 Hour Presumptive Eligibility Program. The provider may not bill the individual when the provider has informed the individual only that the 72 Hour Presumptive Eligibility Program may not pay or where the agreement is contained in a form that the provider routinely requires individuals to sign. A provider may not bill an individual for services when the 72 Hour Presumptive Eligibility Program does not pay as a result of the provider's failure to comply with

applicable enrollment, payment authorization, billing, or other requirements necessary to obtain payment.

6.11 Informal Reconsideration

Claims may be denied for a variety of reasons, including, but not limited to:

- Where an individual for whom services were provided is determined not to be eligible under the 72 Hour Presumptive Eligibility Program. This could occur due to the individual already being enrolled in Montana's Healthcare Programs or in situations where a covered period of crisis stabilization had preceded the service being billed by fewer than seven calendar days;
- Where provided services are denied on the basis of the services requiring a matching payment authorization that is not found;
- Where provided services are denied on the basis that the services were not covered under the 72 Hour Presumptive Eligibility Program; or,
- Where services were delivered following an initial assessment that did not identify a psychiatric crisis.

Participating providers may choose to have such denied claims reviewed by filing an informal reconsideration with the Benefit Management Team of AMDD. This can be done by mailing or faxing a letter to the Benefit Management Team requesting such a review and including copies of all applicable documentation.

AMDD must receive a written request for review within 30 days after the date of a notice denying a claim. The request for reconsideration should be mailed to the following address:

Addictive and Mental Disorders Division

Department of Public Health and Human Services

Post Office Box 202905

Helena, MT 59620-2905

The department will conduct an informal reconsideration and may grant full or partial reimbursement for services provided.

In the event that the reason for denying the services was that the services were rendered within seven calendar days of a previously covered period of crisis stabilization, full or partial reimbursement will be made if the following is determined:

- complications have arisen because of premature discharge or treatment errors in the previous crisis stabilization plan;
- the crisis stabilization services are for a condition that could not have been treated during the previous crisis stabilization plan; or,

- the provider could not have discovered the previous stabilization plan using due diligence.

All requests for informal reconsideration need to be as specific as possible in terms of identifying the individual for whom the disputed services were provided, the date and time that such services were provided, the actual provider of the disputed services, and the names of any individuals at AMDD with whom the provider had contact concerning services provided during the episode in question. All requests for informal reconsideration will be reviewed by the Benefit Management Team of AMDD and a written response will be sent to the provider or provider's representative as noted in the letter requesting the reconsideration. Once the review is completed, all decisions are final.